File: H-02

LAKE COUNTY BOARD OF DD/DEEPWOOD

BOARD POLICY

Reviewed and Adopted by the Board:
Date: February 24, 2020

Signature on File
Elfriede Roman, Superintendent

I. SUBJECT: EMERGENCY MEDICAL TREATMENT AUTHORIZATION (EMTA) AND AUTHORIZATION TO ADMINISTER MEDICATION

II. PURPOSE:

To establish a policy for timely completion of the EMTA for all individuals served by Board operated facilities and recreation programs, and provide authorization for administration of medication by Board employees.

III. REFERENCE:

O.R.C. 3313.712 Emergency Medical Authorization
O.A.C. 5123-4-01 Administration and Operation of County Boards of Developmental Disabilities
LCBDD Policy H-4 Emergency Medical Treatment/Intervention and Do Not Resuscitate ("DNR") Orders
LCBDD Policy A-28 Advance Directives

IV. POLICY:

Within 30 days of enrollment and annually all individuals must have on file appropriate authorization (attached) for emergency medical treatment and administration of medications. If an, individual, parent, or guardian does not wish to give written permission for medical care, Part II, Refusal to Consent shall be completed indicating actions preferred to be taken. If applicable, a properly executed DNR identification form will be attached to the EMTA. The primary program area will keep the original EMTA on file and distribute copies to other program areas as necessary. A copy of this EMTA will be presented to the hospital, physician or other emergency health care provider in the event of a medical emergency. All reasonable attempts will be made by Board employees to contact/notify parents or guardians and when appropriate, other persons having care of the individual including residential services supports providers in the case of medical emergency. Each Program Director will develop procedures to address and insure completion to this policy.

The appropriate EMTA's are as follows:
Attachment A - All individuals
Attachment B - Broadmoor School Students
Attachment C - Adult Program Areas and Residential
(Note: individuals who reside at LCBDD/Deepwood ICF's and attend Broadmoor School will only complete Attachment A & B)

Information received shall be treated as protected health information and be secured and disclosed in accordance with the Health Insurance Portability Act of 1996.

V. DISTRIBUTION:

Board Members
All Management Staff
All Staff (via Department Managers)
LEADD President

VI. REVIEWED:

02/20, 02/18, 02/17, 02/16, 02/15, 02/14, 03/13, 02/12, 02/10, 06/08, 06/06, 05/04, 05/03, 08/01, 06/99

Policy: H-2
Attachment: A

LAKE COUNTY BOARD OF DD/Deepwood
FACE SHEET

Name:_____DOB:_____

Address:_____
(street) (city) (state/zip)

Phone:_____ Sex: M / F Marital Status:_____ SSN:_____

Employer/Program Area:_____

Guardian's Name:_____ Phone: (h)_____
Phone (w/c)_____
Address:_____
(street) (city) (state/zip)

Co/Guardian's Name:_____ Phone: (h)_____
Phone (w/c)_____
Address:_____
(street) (city) (state/zip)

Father:_____Mother:_____
Address:_____Address:_____
_____
Phone: (home)_____Phone: home)_____
(w/c)_____ (w/c)_____

Medicare #:_____Medicaid :_____

Medicare Part D:
Provider:_____
Plan :_____

Other Insurance: (Carrier Name)_____

Contract #:_____ Group #:_____ Service #_____

Emergency Contact:_____
Diagnosis:_____

Allergies:_____

Last Tetanus:_____ Last Pneumovax:_____ Last Influenza:_____

Level of Functioning:_____

Special Considerations:_____

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LAKE COUNTY BOARD OF DD/Deepwood
EMERGENCY MEDICAL AUTHORIZATION
BROADMOOR SCHOOL

Student Name:_____
Address:_____
_____
Phone #:_____

Residential Parent or Guardian:
Mother's Name:_____Daytime Phone:_____
Father's Name:_____ Daytime Phone:_____
Other's Name:_____ Daytime Phone_____
Name of Relative or Childcare Provider:
_____Relationship:_____
Address:_____ Phone:_____

PART I OR II MUST BE COMPLETED

PART I: To Grant Consent

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor:_____ Phone:_____
Dentist:_____ Phone:_____
Medical Specialist:_____ Phone:_____
Local Hospital:_____ ER Phone:_____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctor, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history including allergies, medications being taken, modified diets, diet supplements, fluoride supplements and any physical impairments to which a physician should be alerted:

_____
_____

Date:_____ Signature of Parent/Guardian:_____
Address:_____

PART II: Refusal to Consent

I do NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment. I wish the school authorities to take the following action:

_____
_____

Date:_____ Signature of Parent/Guardian:_____
Address:_____

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3313.712 Emergency Medical Authorization: Form

As used in this section "parent" means parent as defined in section 3321.01 of the Revised Code.

(A) Annually the board of education of each city, exempted village, local and joint vocational school district shall, before the first day of October, provide to the parent of every pupil enrolled in schools under the board's jurisdiction, an emergency medical authorization form that is an identical copy of the form contained in division (B) of this section. Thereafter, the board shall, within thirty days after the entry of any pupil into public school in this state for the first time, provide his parent, either as part of any registration form which is in use in the district, or as a separate form, an identical copy of the form contained in division (B) of this section. When the form is returned to the school with Part I or Part II completed, the school shall keep the form on file, and shall send the form to any school of a city, exempted village, local, or joint vocational school district to which the pupil is transferred. Upon request of his parent, authorities of the school in which the pupil is enrolled may permit the parent to make changes in a previously filed form, or to file a new form.

If a parent does not wish to give such written permission, he shall indicate in the proper place on the form the procedure he wishes school authorities to follow in the event of a medical emergency involving his child.

Even if a parent gives written consent for emergency medical treatment, when a pupil becomes ill or is injured and requires emergency medical treatment while under school authority, or while engaged in an extra-curricular activity authorized by the appropriate school authorities, the authorities of his school shall make reasonable attempts to contact the parent before treatment is given. The school shall present the pupil's emergency medical authorization form or copy thereof to the hospital or practitioner rendering treatment.

Nothing in this section shall be construed to impose liability on any school office or school employee, who, in good faith, attempts to comply with this section.

AUTHORIZATION TO ADMINISTER MEDICATION

Medications, food supplements, fluoride supplements, and modified diets are administered to consumers by a licensed nurse or ODDD certified DD personnel while attending LCBDD/Deepwood programs (excluding self administered medications). A physician order is required for all prescription and non-prescription drugs, food supplements, fluoride supplements, and modified diets. It is the responsibility of the consumer/guardian/residential provider to provide a complete list of medications, food supplements, fluoride supplements, and modified diets as well as the medication and above mentioned supplements and specialized food supplements needed by the consumer. Notification to the nursing department of any changes in medication or diet is the sole responsibility of the consumer/guardian/residential provider. I have been informed of the risks and benefits of these medications & diets by the prescribing health care professional and I consent to their administration.

_____ _____

Signature of Parent/Guardian Date

(B) The emergency medical authorization form provided for in division (A) of this section is attached as B, 1.

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LAKE COUNTY BOARD OF DD/DEEPWOOD
EMERGENCY MEDICAL AUTHORIZATION

Individual Name: _____ Program(s) _____

Address: _____ Phone: _____

City/Zip_____

Guardian/Provider Name: _____Daytime Phone: _____
Address: _____ Phone (other): _____
City/Zip: _____

Co/Guardian _____Daytime Phone: _____
Address: _____ Phone (other): _____
City/Zip: _____

PART I OR II MUST BE COMPLETED

PART I: To Grant Consent

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor:_____ Phone:_____
Dentist:_____ Phone:_____
Medical Specialist:_____ Phone:_____
Local Hospital:_____ ER Phone:_____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctor, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history including allergies, medications being taken, modified diets, diet supplements, fluoride supplements and any physical impairments to which a physician should be alerted:

_____
_____

Date:_____ Signature of Individual/Guardian:_____

PART II: Refusal to Consent

I do NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment. I wish the school authorities to take the following action:

_____
_____

Date:_____ Signature of Parent/Guardian:_____

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EMERGENCY MEDICAL AUTHORIZATION SECTION 3313.712, OHIO REVISED CODE

(A) Annually the Lake County 169 Board shall provide to individuals (guardian) enrolled in any program under the Board's jurisdiction, an emergency medical authorization form that is an identical copy of the form contained in division (B) of this section.

When the form is returned to the program area with Part I or Part II completed, the primary program area shall keep the form on file, distributing copies to other areas in which the individual participates. Upon request of the individual (guardian), the program director may permit changes in previously filed form to be made, or to file a new form.

If the individual (guardian) does not wish to give such written permission, (s)he shall indicate in the proper place on the form the procedure (s)he wishes Board authorities to follow in the event of a medical emergency involving the individual.

Even if the individual (guardian) gives written consent for emergency medical treatment, when an individual becomes ill or is injured and requires emergency medical treatment while engaged in Board activities, Board authorities shall make reasonable attempts to contact the guardian or emergency contact before the treatment is given. The Board authority shall present the individual's emergency medical authorization form or copy thereof to the hospital or practitioner rendering treatment.

Nothing in this section shall be construed to impose liability on any board official or Board employee who, in good faith, attempts to comply with this section.

AUTHORIZATION TO ADMINISTER MEDICATIONS

Medications are administered to consumers by a licensed nurse or ODDD certified DD personnel while attending LCBDD/Deepwood programs (excluding self administered medications). A physician order is required for all prescription and non-prescription drugs, food supplements and modified diets. It is the responsibility of the consumer/guardian/residential provider to provide a complete list of medications, food supplements and modified diet orders as well as the medication and above mentioned specialized food supplements needed by the consumer. Notification to the nursing department of any changes in medication or diet is the sole responsibility of the consumer/guardian/residential provider. I have been informed of the risks and benefits of these medications & diets by the prescribing health care professional and I consent to their administration.

_____ Date:_____
Signature of Individual/Guardian

(B) The emergency medical authorization form provided for in division (A) of this section is attached as C, 1.